Retirement/ Disability Retirement

Retirement/Disability Retirement Table of Contents

Benefits for Retirees

Benefits available to you in retirement are the focus of this chapter. It is designed to provide useful information to eligible participants in the state insurance program who are considering retirement or who have already retired. For more detailed information on specific programs, please refer to the previous chapters in this guide. If you have questions or need additional information about your insurance, contact EIP through our Web site at www.eip.sc.gov or call 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

A checklist that will help you find information you need to know when you retire is on page 24.

ARE YOU ELIGIBLE FOR RETIREE INSURANCE?

Retirees **from employers that participate in the state insurance program** are eligible for insurance coverage if they retire:

- Due to years of service with a participating state insurance employer
- Due to age
- On approved disability through the S.C. Retirement Systems (SCRS) or on approved Basic Long Term Disability and/or Supplemental Long Term Disability.

For more information about state retirement eligibility, call 803-737-6800 (Greater Columbia area) or 800-868-9002 (toll-free outside the Columbia area but within South Carolina) or visit the S.C. Retirement Systems Web site at www.retirement.sc.gov.

To qualify for the retiree group insurance program as either a non-funded or a funded retiree, your last five years of employment must be served consecutively, with an employer that participates in the Employee Insurance Program, and in a full-time, permanent position.

Additional service credit for unused sick leave may not be used to qualify for the retiree group insurance program.

State Optional Retirement Program retirees must meet the same insurance eligibility guidelines as S.C. Retirement Systems participants.

Please note: Whether you are a funded or a non-funded retiree, the following types of service do not count toward your 5-, 10- or 20-year requirement for insurance eligibility: non-qualified, federal, military, out-of-state employment, unused sick leave or service with employers that do not participate in the state insurance program.

If you are not eligible for insurance as a retiree, you may still be eligible to continue coverage under COBRA (see page 18).

WHO PAYS FOR YOUR INSURANCE?

If you are a state or school district retiree and qualify for funded benefits, the state will contribute as much to your premiums as it contributes to the premiums of an active employee.

Local subdivisions may or may not pay a portion of the cost of their retirees' group insurance premium. Each local subdivision develops its own policy for funding retiree insurance premiums.

A *local subdivision* is a public employer in South Carolina that falls within one of the categories established by Section 1-11-720 of the 1976 S.C. Code of Laws, as amended, such as a city or county, and participates in the state insurance program. **If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.**

Funded Retirees

Funded retirees are those whose employer contributes to their retiree insurance premiums and whose last five years of employment were continuous and consecutive in a permanent, full-time position with an employer that participates in the state insurance program. They must fall into one of these categories:

For information on eligibility requirements for dependents and on adding them to your coverage, see page 10.

- Employees who leave employment when they are eligible to retire and have at least 10 years of earned S.C. Retirement Systems (SCRS) service credit with an employer that participates in the state insurance program.
- Employees who leave employment before they are eligible to retire and who have at least 20 years of earned SCRS service credit with an employer that participates in the state insurance program. These employees are not eligible for insurance coverage until age 60 when they are eligible to receive a retirement check. Employees who qualify under the Police Officers Retirement System (PORS) become eligible at age 55.
- **An exception:** Employees who left employment before 1990 and who were not eligible to retire, but who had 18 years of earned SCRS service credit and returned to work with a participating group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

Non-funded Retirees

Non-funded retirees are those who do not qualify for funded benefits (see previous rules) and who must pay the full premium, which includes the retiree share plus the employer contribution. For retirees of local subdivisions, it may also include an administrative fee and an experience rating. To qualify, a retiree's last five years of employment must have been continuous and consecutive in a permanent, full-time position with an employer that participates in the state insurance program. Non-funded retirees include:

- Employees who retire at age 55 with at least 25 years of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. Although sick leave may increase service credit under SCRS, retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. At the end of this period, you will be eligible for funded retiree rates. This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judges-Solicitors Retirement System participants. If you are in one of these groups, contact your benefits office for additional information. If you are retiring from a local subdivision, contact your benefits administrator for premium information.
- Employees who are eligible to retire and have at least five, but fewer than 10, years of earned SCRS service credit with a participating state insurance program employer.
- General Assembly members who leave office or retire with at least eight years of General Assembly Retirement System service credit.
- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plans when they left the council. It is up to the county or municipal council to decide whether to allow former members to have this coverage.

TERI

If you are a Teacher and Employee Retention Incentive (TERI) program participant in a permanent, full-time position, your insurance benefits as an active employee continue. When your active insurance benefits end, you must apply for continuation of your insurance benefits as a retiree (if eligible) within 31 days of your date of termination. Your service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward retiree insurance eligibility.

Retiree Premiums and Premium Payment

State Agency, Higher Education and School District Retirees
Your health, State Dental Plan, Dental Plus and Long Term Care premiums are deducted from your monthly S.C. Retirement Systems (SCRS) pension check.

Your retirement pension is paid at the end of the month, and your insurance premiums are paid at the beginning of the month. For example: your insurance premiums for April are deducted from your March retirement check.

Your insurance premiums may be due before your retirement paperwork has been finalized by SCRS or EIP. If this happens, you will receive a monthly bill for the premiums until you receive your first retirement check. If you do not pay the bill, the total premiums due will be deducted from your first retirement check.

Retiree insurance premiums are listed beginning on page 210.

Please note: Depending on the date you retire, premiums for two or more months may be deducted from your first retirement check. If, at any time, the total premiums are greater than the amount of your check, EIP will bill you directly for the full amount.

Local Subdivision Retirees
You pay your health, State Dental Plan, Dental Plus and Long Term Care premiums directly to your former employer. That employer decides what portion of the premium it will pay. Contact your benefits office for information about your insurance premiums in retirement.

ENROLL WITHIN 31 DAYS OF YOUR RETIREMENT

Your insurance will NOT be automatically continued when you retire. In addition to completing your paperwork with the S.C. Retirement Systems (SCRS), **you must contact EIP within 31 days of the date of your retirement to arrange for your retiree insurance.** Please visit our office in Suite 300, 1201 Main St., Columbia, if you would like to see an EIP representative. We do not schedule appointments. You may also request a retiree insurance enrollment packet by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area) or print forms from the EIP Web site, www.eip.sc.gov. Choose your category, "Retirees," and then "Forms." You must complete the Retiree Notice of Election form and the Employment Verification Record. You may also need the Notice of Continuation of (Life) Coverage and the Group Life Portability Enrollment form.

HOW TO ENROLL

If you are an eligible retiree, you must enroll by filing a Retiree Notice of Election (NOE) form and an Employment Verification Record within 31 days of:

- Your retirement date or
- The end of your TERI period or
- The date on the letter approving your SCRS disability retirement or your Basic and/or Supplemental Long Term Disability benefits or
- A *special eligibility situation*.

You may enroll yourself and any eligible dependents. (However, you are not required to cover the same eligible dependents as a retiree that you covered as an active employee.)

If you and/or your eligible dependents are **not covered by a state health plan** at the time of your retirement, you may enroll within 31 days of:

- Your retirement date or
- The end of your TERI period or
- A *special eligibility situation*.

A *special eligibility situation* is created by a qualifying event. It allows eligible employees and retirees to enroll in an insurance plan. Enrollment changes must be requested within 31 days of the *qualifying event*.

Examples of a *qualifying event* include: marriage, birth, adoption or placement for adoption. Involuntary loss of other coverage is a qualifying event only for those who lost coverage.

You will be subject to *pre-existing condition* exclusions for 12 months. Proof of *creditable coverage* may be used to reduce a pre-existing condition exclusion period, if any break in coverage did not exceed 62 days. Those enrolling who have had a break in health coverage of more than 62 days will be subject to pre-existing condition exclusions for 12 months.

For more information about the pre-existing condition exclusion, see page 11.

Late Entrants

If you and/or your dependents do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll as a late entrant during an open enrollment period held in October of every odd-numbered year (e.g., October 2009). Your coverage will take effect on the following January 1 (January 1, 2010), but, as a late entrant, your coverage will be subject to pre-existing condition exclusions for 18 months. Proof of creditable coverage may be used to reduce a pre-existing condition exclusion period, if any break in coverage did not exceed 62 days.

YOUR HEALTH PLAN CHOICES AS A RETIREE

If You Are Not Eligible for Medicare

You and your covered dependents who **are not** eligible for Medicare may be covered under one of these plans:

- The SHP Savings Plan (You may contribute to an HSA, but not through MoneyPlu$.)
- The SHP Standard Plan
- An HMO offered in the county where you live. (See page 62 for counties where each HMO is available.)

Please note: If the retiree is not eligible for Medicare but the spouse is, the retiree can enroll in the Savings Plan and contribute to an HSA.

Your health benefits, which are described in a previous chapter, will be the same as if you were an active employee. However, your premiums may change depending on whether you are a funded or a non-funded retiree. Refer to pages 210 - 211 for premiums.

If You Are Eligible for Medicare

You and/or your covered dependents who **are** eligible for Medicare may be covered under one of these plans:

- The SHP Standard Plan
- The SHP Medicare Supplemental Plan
- An HMO offered in the county where you live. (See page 62 for counties where each HMO is available.)

This section provides details on the benefits available to you. Please note that if you are eligible for Medicare, you may not enroll in the Savings Plan, and you cannot contribute to a Health Savings Account associated with the Savings Plan.

WHEN YOUR COVERAGE AS A RETIREE BEGINS

Even if you go directly from active employment to retirement, you still have to enroll as a retiree. Your retiree coverage will begin the day after your active coverage ends. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the qualifying event or the first of the month after the qualifying event. If you enroll during open enrollment your coverage will be effective the following January 1.

Information You Will Receive

After you enroll, you will receive a letter from the Employee Insurance Program that confirms you have retiree group coverage. Because your coverage as an active employee is ending, federal law requires that you also be sent:

- A Certificate of Creditable Coverage, which gives the dates of your active coverage, the names of the individuals covered and the types of coverage
- A Qualifying Event Notice, which tells you that you may continue your active coverage under COBRA.

Typically, these letters require no action on your part.

Your Insurance Identification Card in Retirement

Keep your identification card if you do not change plans when you retire. You and your covered dependents will not receive new cards at retirement if you remain covered under any State Health Plan option or the State Dental Plan and Dental Plus. You will receive a new health identification card if you are changing from an HMO to any State Health Plan option or vice versa and/or if you enroll in the State Dental Plan or Dental Plus for the first time. If your card is lost, stolen or damaged, you may request a new card from EIP or from these third-party administrators:

- State Health Plan — BlueCross BlueShield of South Carolina
- HMO — CIGNA HealthCare, BlueChoice HealthPlan or MUSC Options
- Dental Plus — BlueCross BlueShield of South Carolina.

Contact information for the third-party administrators is on the inside cover of this guide.

Decreasing Coverage

If a spouse or dependent child becomes ineligible, you must drop him from your health and/or dental coverage. This may occur because of divorce or separation, a child turns 19 and is no longer a full-time student, a child turns 25, a child marries or a child is no longer principally dependent (more than 50 percent) on you for support. If you drop a dependent from your coverage, you must complete an NOE within 31 days of the date he becomes ineligible.

RETURNING TO WORK

Deciding on Coverage

If you are covered under the retiree group insurance program and return to active employment in a permanent, full-time position, you must decide whether to be covered under active group employee benefits or to continue your retiree group benefits. You cannot be covered under both. If you prefer to continue your retiree group insurance benefits, you must complete and sign an Active Group Benefits Refusal form.

Remember, if you refuse to enroll as an active employee, you are also refusing benefits that are available only to active employees:

- $3,000 Basic Life benefit
- Basic and Supplemental Long Term Disability coverage
- Dependent Life Insurance
- Optional Life Insurance
- MoneyPlu$ benefits.

Note: If you carried your Optional Life coverage into retirement and/or converted your Dependent Life coverage, and are billed by The Hartford, you must decide if you want coverage as a retiree or as an active employee. You cannot have both.

If You Are Enrolled in Medicare

If you are enrolled in Medicare and return to active employee benefits, Medicare will pay after your active group coverage. Therefore, you must notify Social Security that you are covered under the active group, and you may elect to drop Medicare Part B while you are covered as an active employee.

When you leave active employment and your active group coverage ends, you may return to retiree group coverage within 31 days of your active termination date. You must file an enrollment form to return to the state retiree group. In addition, you must notify Social Security that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

Retiring Again Before Medicare Eligibility at Age 65

If you retired and returned to work and will retire again within 60 to 90 days of becoming Medicare eligible at age 65, you must contact the Social Security Administration to enroll in Medicare Parts A and B.

WHEN COVERAGE ENDS

Your coverage will end:

- The day after your death
- The date it ends for all employees and retirees
- If you do not pay the required premium when it is due.

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered
- The last day of the month your dependent is no longer eligible for coverage. If your dependent's coverage ends, he may be eligible for continuation of coverage under COBRA (see page 18).

If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

Death of a Retiree

If a retiree dies, a surviving family member should contact EIP to report the death and end the retiree's health coverage. If the deceased was a retiree of a local subdivision, contact his benefits administrator.

Survivors of a Retiree

Spouses or children who are covered as dependents under the State Health Plan or an HMO are classified as "survivors" when a covered employee or retiree dies. Survivors of funded retirees may be eligible for a one-year waiver of health insurance premiums.

For a checklist of information that may be helpful when a loved one dies, see page 25.

Survivors of non-funded retirees may continue their coverage. However, they must pay the full premium. Participating local subdivisions may, but are not required to, waive the premiums of survivors of retirees, but a survivor may continue coverage, at the full rate, for as long as he is eligible. If you are a retiree of a participating local subdivision, check with your benefits administrator to see whether the waiver applies.

After the first year, a survivor who qualifies for the waiver must pay the full premium to continue coverage. If you and your spouse are both covered employees or funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

State Dental Plan and Dental Plus premiums are not waived. However, survivors can continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. If your spouse retired from a state agency, a college or university or a school district, contact EIP for more information. If your spouse retired from a local subdivision, contact his benefits administrator.

As long as a survivor remains covered by health or dental insurance, he can add either at open enrollment. If he has health and dental and drops both, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a survivor becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage

When You or Your Dependents Become Eligible for Medicare

About Medicare

Medicare includes *Part A*, *Part B and Part D*. To find out more:

- Read *Medicare & You 2008.*
- Visit the Medicare Web site at www.medicare.gov.
- Call Medicare at 800-633-4227 or 877-486-2048 (TTY).

Medicare Part A
Part A is your hospital insurance. Most people do not pay a premium for Part A because they or their spouse paid Medicare taxes while they were working. Part A helps cover your inpatient care in hospitals, in critical access hospitals in rural areas and in skilled nursing facilities. Part A has an inpatient hospital deductible for each benefit period. For 2008, it is $1,024. Part A also covers hospice care and some home healthcare. You must meet certain requirements to be eligible for Part A. Contact Medicare for additional information.

Medicare Part B
Part B is your medical insurance. Most people do pay a premium through the Social Security Administration for Part B. It helps cover doctors' services and outpatient hospital care. It also covers some medical services that Part A does not cover, such as some of the services of physical and occupational therapists and home

healthcare. Part B pays for these covered services and supplies when they are medically necessary. In 2008, the Part B deductible is $135 a year.

When you become eligible for Medicare, it is important to be enrolled in Part B if you are covered as a retiree or as a dependent of a retiree. Medicare becomes your primary insurance, and your retiree group insurance becomes the secondary payer. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

Medicare Part D
Part D, the prescription drug plan, became effective January 1, 2006. However, most subscribers covered by the Standard Plan, the Medicare Supplemental Plan or the health maintenance organizations offered through the Employee Insurance Program (EIP) should not sign up for Medicare Part D.

The prescription drug benefit provided through your health plan is as good as, or better than, Part D for most people. Because you have this coverage, your drug expenses will continue to be reimbursed through your health insurance. Before you turn 65 and become eligible for Medicare, you will receive a Notice of Creditable Coverage letter from EIP officially notifying you that you do not need to sign up for Part D. There is a copy of the letter on pages 229-231. (If you become eligible for Medicare before age 65, the letter will not be sent to you.)

IMPORTANT MEDICARE NOTE

If you or one of your dependents become eligible for Medicare due to age or disability, you must notify EIP within 31 days of eligibility. If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- **Begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

If you or your eligible dependent enrolls in Medicare Part D, you, or he, will lose the prescription drug coverage provided by your health plan with EIP. However, the premium for your health plan will not be reduced.

You may have heard that if you do not sign up for Part D when you are first eligible — then later do so — you will have to pay higher premiums for Part D. For EIP subscribers, this is not true. According to Medicare rules, Medicare recipients who have "creditable coverage" (drug coverage that is as good as, or better than, Part D) and who later decide to sign up for Part D, will not be penalized by higher Part D premiums. Subscribers to the health plans offered through EIP have creditable coverage. However, please save your Notice of Creditable Coverage letter from EIP in case you need to prove you had this coverage when you became eligible for Part D.

Most people should not respond to information they may get from Medicare or advertisements from companies asking them to buy Part D prescription drug plans.

The federal government does offer extra help in paying for Medicare Part D, but not EIP drug coverage, for people with limited income and resources. If you think you may qualify for this assistance, go to the Social Security Administration's Web site at www.socialsecurity.gov or call 800-772-1213 or 800-325-0778 (TTY).

Please remember: Medicare Part D does not affect your need to enroll in Medicare Part B (medical insurance). As a retiree covered under EIP's insurance, you must enroll in Part A and Part B when you become eligible for Medicare due to a disability or due to age. If you are not enrolled in both parts of Medicare, you will be required to pay the portion of your healthcare costs that Medicare would have paid.

Medicare Before Age 65: Disability Retirees

If you or your spouse becomes eligible for Medicare before age 65 due to disability, including end-stage renal disease (ESRD), you must notify EIP within 31 days of Medicare eligibility. When you notify EIP, please submit a copy of your Medicare card.

Because Medicare is primary (pays first) over your retiree health insurance plan, when you become eligible for Medicare, you must enroll in Medicare Part A and Part B. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid. EIP will not pay these costs.

If you do not enroll in Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from January 1 to March 31 of each year, and coverage begins on July 1. Your Medicare premium will be 10 percent higher for each year you did not enroll in Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

If you wish to switch to the Medicare Supplemental Plan, you must complete a Notice of Election form within 31 days of Medicare eligibility. You will not be automatically enrolled in the plan.

IF YOU HAVE END-STAGE RENAL DISEASE
You will become eligible for Medicare three months after beginning dialysis. At this point, a 30-month "coordination period" begins. During this period, your health coverage through EIP is primary, which means it pays your medical claims first. After 30 months, Medicare becomes your primary coverage. Please notify EIP within 31 days of the end of the coordination period. At that time, you will have the option of changing to the Medicare Supplemental Plan. (The Medicare Supplemental Plan is not available to active employees or their covered dependents.)

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered dependent and whether you were already eligible for Medicare for another reason, such as your age. If you were covered by the Medicare Supplemental Plan, you will be switched the Standard Plan for the 30 months of the coordination period.

Medicare At 65 if You Are Retired

At age 65, Medicare is primary (pays first) over your retiree health insurance plan. You must enroll in Medicare Part A and Part B. If you do not enroll in Medicare A and B you will be required to pay the portion of your healthcare costs that Medicare would have paid.

Medicare's Initial Enrollment Period starts three months before the month you turn age 65 and extends three months past the month you turn 65. If you are not receiving Social Security benefits, you should inquire about filing for Medicare three months before you turn age 65 so your Medicare coverage can start the month you turn 65.

If you are receiving Social Security benefits, you should be notified of Medicare eligibility by the Social Security Administration three months before you reach age 65. Medicare Part A starts automatically, and you must enroll in Part B. If you are not notified, contact your local Social Security office immediately.

If you decide not to receive Social Security benefits until you reach **your** full Social Security retirement age, you must still apply for Medicare A and B benefits. We recommend you contact the Social Security Administration within three months of your 65th birthday to enroll. The Social Security Administration will bill you quarterly for the premium for Medicare Part B.

When you enroll in Medicare, you should notify EIP and send in a copy of your Medicare card.

If You Are an Active Employee at Age 65

If you are actively working and/or covered under a state health plan for active employees, you may defer enrollment in Part B because your insurance as an active employee remains primary while you are actively working.

If you are an active employee but your spouse is eligible for Medicare, your spouse should enroll in Part A but may delay enrollment in Part B until you retire and your active coverage ends.

When you become eligible for Medicare due to age or disability, you MUST notify EIP within 31 days.

Social Security has a special enrollment rule for employees ending active employment after age 65. You should contact the Social Security Administration within 90 days of your retirement date to ensure that your Medicare A and B coverage begins on the same date as your retiree coverage.

Remember: When you retire you must sign up for Part A and Part B within 31 days of retirement because Medicare becomes your primary coverage.

Sign up for Parts A and B of Medicare

You must enroll in both Part A and Part B of Medicare to receive full benefits with any state-offered retiree group health plan. If you are not enrolled in both parts of Medicare, you will be required to pay the portion of your healthcare costs that Medicare Part B would have paid.

Medicare Assignment: How Medicare Pays Its Share of the Cost of Your Care

Under Medicare assignment, the Medicare subscriber agrees to have Medicare's share of the cost of services paid directly ("assigned") to a provider. Participating providers have agreed to submit all of their Medicare claims on an assigned basis. Non-participating providers may choose whether to accept assignment on each individual claim. If you receive services from a non-participating physician, ask if he will accept assignment.

Each year, doctors and suppliers have the opportunity to participate in Medicare. After you meet your deductible and pay your coinsurance, if it applies, doctors and suppliers participating in the program will accept the Medicare-approved amount as payment in full. If a doctor does not accept assignment, you may pay more for his services.

If a doctor decides to participate, he cannot drop out in the middle of the year. Independent laboratories and doctors who perform diagnostic laboratory services and non-physician practitioners must accept assignment.

YOUR HEALTH OPTIONS WITH MEDICARE

When you and/or your eligible dependents are covered under retiree group health insurance and become eligible for Medicare, Medicare becomes the primary payer, and your health options change. Before you turn 65, EIP will send you a letter offering you and your eligible dependents a choice of the Standard Plan, the Medicare Supplemental Plan, CIGNA Healthcare HMO, BlueChoice HealthPlan or MUSC Options. (To enroll in an HMO, it must be offered in the county in which you live.)

Would you like more information about your health insurance choices when you become eligible for Medicare? See page 200 for a comparison table.

If you become eligible for Medicare due to age, and you are covered by the Standard Plan or the Savings Plan, you will be automatically enrolled in the Medicare Supplemental Plan unless you respond to the letter by choosing another plan. Coverage changes must be made within 31 days of the date you become eligible for Medicare.

If you are enrolled in the Medicare Supplemental Plan, the claims of your eligible dependent(s) without Medicare are paid through the Standard Plan's provisions.

The Savings Plan is not available to you if you are retired and eligible for Medicare.

THE STANDARD PLAN

The State Health Plan Standard Plan offers worldwide coverage. It requires Medi-Call approval for inpatient hospital admissions; all maternity benefits (you must call in the first trimester); outpatient surgical services in a hospital or clinic; the purchase or rental of durable medical equipment; and skilled nursing care, hospice care and home healthcare. **You must also call APS Healthcare, Inc., the SHP's behavioral health manager, for preauthorization before you receive mental health or substance abuse care.**

The plan has both deductibles and coinsurance. Once you become eligible for Medicare, Medicare becomes your primary insurance coverage. The Standard Plan uses a carve-out method, which is described on page 183, to pay your claims.

HOW THE STANDARD PLAN AND MEDICARE WORK TOGETHER

Using Medi-Call as a Retiree

Medicare has its own program for reviewing use of its benefits. However, you still need to call Medi-Call when Medicare benefits are exhausted for inpatient hospital services (including hospital admissions outside South Carolina or the U.S.), and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services.

For information about services that require preauthorization under the State Health Plan, see
- **Medi-Call: page 39**
- **APS: page 58**

Note: Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call Medi-Call.

Please remember that while your physician or hospital may call Medi-Call for you, it is your responsibility to see that the call is made.

Hospital Network

When you are eligible for Medicare, Medicare is the primary payer, and you may go to any hospital you choose. Medicare limits the number of days it will cover for hospital stays. If you are enrolled in the Standard Plan and your hospital stay exceeds the number of days allowed under Medicare, it may be important to you that you are admitted to a hospital within the State Health Plan network or BlueCard Program so that you will not be charged more than what the Standard Plan allows. *Note: Mental health and substance abuse services are covered only at APS Healthcare, Inc., network facilities.*

You must also call Medi-Call for approval of any additional inpatient hospital days beyond the number of days approved under Medicare and for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Private Duty Nursing if You Have Medicare

Medicare does not cover private duty nursing. However, the Standard Plan does cover medically necessary, intermittent private duty nursing services. The regular coinsurance rate and the deductible, if you have not satisfied it, apply for approved charges. Remember to call Medi-Call for private duty nursing services.

When Traveling Outside South Carolina

You are not generally covered outside the United States under Medicare. However, if you are enrolled in the Standard Plan, you have worldwide access to doctors and hospitals through the BlueCard program. If you are admitted to a hospital outside the state or the country as a result of an emergency, notify Medi-Call and follow the BlueCard guidelines. For more information, see page 36.

Mental Health and Substance Abuse: Using APS as a Retiree

If you are eligible for Medicare and covered under the Standard Plan, you must call APS Healthcare, Inc., the SHP's behavioral health manager, at 800-221-8699 for approval of inpatient hospital stays. Preauthorization and continued-stay authorizations by APS are required for inpatient care, including care in a Veterans Administration hospital. If your Medicare benefits are exhausted, you must call APS to receive authorization for continued benefits under the Standard Plan. To receive benefits, you must use an APS network provider.

Note: Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must also call to register with APS and use an APS network provider.

Prescription Drug Program

The Standard Plan covers prescription drugs when purchased from a participating pharmacy. Please refer to page 54 for more information on the State Health Plan Prescription Drug Program.

Ambulatory Surgical Center Network

These facilities provide some of the same services offered in the outpatient department of a hospital. If you are enrolled in Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a center that participates in the network.

Transplant Contracting Arrangements

As part of this network, you have access to the leading transplant facilities in South Carolina and throughout the nation. If you are enrolled in Medicare, there is no need to call Medi-Call for preauthorization, nor do you need to select a facility that participates in the network.

Mammography Testing Benefit

The State Health Plan pays for routine mammograms for covered women ages 35-74. You may have one baseline mammogram if you are age 35-39 and one routine mammogram every year if you are age 40-74. There is no charge if you use a facility that participates in the program's network.

Medicare allows yearly routine mammograms for women ages 40 and older and pays 80 percent of Medicare-approved amount. Check with the testing facility to see if it accepts Medicare assignment.

Pap Test Program

The SHP will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women ages 18-65. This benefit does not include the doctor's office visit or other lab tests. Medicare covers a Pap test, pelvic exam and clinical breast exam *every other year*. (If you are at high risk, you may have one yearly. Check with Medicare for more information.) Medicare pays 100 percent for the test, 80 percent for the exam and collection. Please note that the Standard Plan will pay for Pap tests *every year,* so you may take advantage of this benefit in the years that Medicare does *not* pay.

Maternity Management and Well Child Care Benefits

The State Health Plan offers two programs geared toward early detection and prevention of illness among children. The Maternity Management benefit helps mothers-to-be receive necessary prenatal care. (This benefit applies to covered retirees and their spouses. It does not apply to dependent children.) Covered dependent children ages 18 and younger are eligible for Well Child Care check-ups. On page 52 of the State Health Plan section is a schedule of routine immunizations for which the plan pays 100 percent when a network doctor provides the services. If your covered child has delayed, or missed, receiving immunizations at the recommended time, the plan will pay for "catch-up" immunizations through age 18 for the vaccines listed.

"CARVE-OUT" METHOD OF CLAIMS PAYMENT

When a retired subscriber is covered by Medicare, Medicare pays first, and the Standard Plan pays second. If your provider accepts the amount Medicare allows as payment in full, the Standard Plan will pay the lesser of:

1. The amount Medicare allows, minus what Medicare reported paying or
2. The amount the State Health Plan allows, minus what Medicare reported paying.

If your provider does not accept the amount Medicare allows as payment in full, the Standard Plan pays the difference between the amount the State Health Plan allows and the amount Medicare reported paying. The Standard Plan will never pay more than the State Health Plan allows. If the Medicare payment is more than the amount the State Health Plan allows, the Standard Plan pays nothing.

***Example**:*
Medicare is primary. The hospital bill for a January admission is $7,500. If you are enrolled in the Standard Plan and Medicare, your Medicare claim will be processed like this:

$7,500	Medicare-approved amount
- 1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

Next, Standard Plan benefits are applied to the Medicare-approved amount:

$7,500	State Health Plan allowable charge
- 350	Standard Plan deductible for 2008
$7,150	Standard Plan's responsibility after deductible
x 80%	Standard Plan coinsurance
$5,720	Standard Plan payment
- 6,476	Medicare payment is "carved out" of the Standard Plan payment.
$ 0	Standard Plan pays nothing. You pay $1,024.

Under the carve-out method, you pay the Standard Plan deductible and coinsurance or the balance of the bill, whichever is less. In this example, the $350 deductible and your 20 percent coinsurance is $1,780. However, the balance of the bill is $1,024, so you pay the lesser amount, $1,024.

Once you reach your $2,000 coinsurance maximum, all claims will be calculated at 100 percent of the allowable charge based on the carve-out method of claims payment. All of your Medicare deductibles and your Medicare Part B 20 percent coinsurance should be paid in full for the rest of the calendar year after you reach your $2,000 coinsurance maximum.

FILING CLAIMS AS A RETIREE

If you are retired and enrolled in Medicare, Medicare is your primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the State Health Plan for you. Your mental health and substance abuse provider should file claims for you with APS, including Medicare payment information. If you or your doctor have not received payment or notification from the State Health Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina, claims administrator for the State Health Plan, a claim form and a copy of your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," with your Benefits Identification Number or Social Security Number written on it.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file the claim with the Medicare carrier in that state. If you or your doctor have not received payment or notification from the State Health Plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina, third-party administrator for the SHP, a claim form and a copy of your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," with your Benefits Identification Number or Social Security Number written on it. For mental health and substance abuse claims, you must send your Medicare Summary Notice to APS Healthcare, Inc.

If Medicare Denies Your Claim

If Medicare denies your claim, including denied Pap test claims, you are responsible for filing the denied claim to BlueCross BlueShield of South Carolina (BCBSSC). You may use the same SHP claim form as active employees do. These forms are available from EIP or BCBSSC. You will need to attach your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," and an itemized bill to your claim form.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits, mail it, along with an itemized bill and claim form, to BlueCross BlueShield of South Carolina for processing.

THE MEDICARE SUPPLEMENTAL PLAN

If you are a retiree enrolled in the Standard Plan or the Savings Plan and become eligible for Medicare **due to your age,** you will receive a letter from EIP stating that you will be enrolled automatically in the Medicare Supplemental Plan. If you prefer another health plan, you must inform EIP by responding to the letter within 31 days of Medicare eligibility.

If you are enrolled in a health plan offered through EIP, you may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility. During the yearly October enrollment period, you can change from the Standard Plan or an HMO available in the county in which you live, to the Medicare Supplemental Plan or vice versa. Plan changes are effective on January 1 after the enrollment period.

This section explains the SHP Medicare Supplemental Plan, which is available to retirees and covered dependents who are enrolled in both Parts A and B of Medicare. This plan coordinates benefits with the original Medicare Plan only. **No benefits are provided for coordination with Medicare Advantage Plans.** For more information, visit www.medicare.gov or call 800-633-4227.

General Information

The Medicare Supplemental Plan is similar to a Medigap policy — it "fills the gap" or pays the portion of Medicare-approved charges that Medicare does not, such as Medicare's deductibles and coinsurance. The Medicare Supplemental Plan payment is based on the Medicare-approved amount. Except as specified on pages 186-187, charges that are not covered by Medicare will not be payable as benefits under the Supplemental Plan.

For example:
In an outpatient setting, such as an emergency room, Medicare does not cover drugs that a person usually administers to himself, such as pills. This means that if a patient receives pain pills in an emergency room, the hospital will bill him for the drugs. Because Medicare does not pay for the pills, the Medicare Supplemental Plan will not pay for them either.

If your medical provider does not accept Medicare assignment, and charges you more than what Medicare allows, you pay the difference.

Using Medi-Call
Medicare has its own program for reviewing use of its services. You need to call Medi-Call only when Medicare benefits are exhausted for inpatient hospital services and for extended care services, such as skilled nursing facilities, private duty nursing, home healthcare, durable medical equipment and Veterans Administration hospital services.

Note: *Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call Medi-Call.*

MEDICARE DEDUCTIBLES AND COINSURANCE

Deductibles

Medicare Part A has an inpatient hospital deductible for each *benefit period*. That deductible for 2008 is $1,024. A Medicare benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received any hospital or skilled care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. *The Medicare Supplemental Plan will pay the Part A deductible each time it is charged.*

Medicare Part B has a deductible of $135 a year in 2008. Part B, for which you pay a monthly premium, covers physician services, supplies and outpatient care. Please contact Medicare for more information. As a retiree, you must enroll in Part B as soon as you are eligible for Medicare, because Medicare is your primary coverage. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid. *The Medicare Supplemental Plan pays the Part B deductible.*

Coinsurance

Medicare Part B pays 80 percent of the Medicare-approved amount (50 percent for outpatient mental healthcare). *The Medicare Supplemental Plan pays the remaining 20 percent (50 percent for outpatient mental healthcare).*

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MEDICARE SUPPLEMENTAL PLAN DEDUCTIBLES AND COINSURANCE

The Medicare Supplemental Plan benefit period is from January 1-December 31 and includes a $200 deductible each calendar year that applies to private duty nursing services only. If you become eligible for Medicare and change to the Medicare Supplemental Plan during the year, you must meet a new $200 deductible for private duty nursing services. You do not have to meet another $200 deductible for private duty nursing services if you remain enrolled in the Standard Plan.

WHAT THE MEDICARE SUPPLEMENTAL PLAN COVERS

Hospital Admissions

The Medicare Supplemental Plan pays these expenses for Medicare-covered services after Medicare Part A benefits have been paid during a benefit period:

- The Medicare Part A hospital deductible
- The coinsurance, after Medicare pays, for days 61-150 of hospitalization, up to the Medicare-approved amount (Medicare pays 100 percent for the first 60 days)
- 100 percent of the Medicare-approved amount for hospitalization through 60 days if you have used up your lifetime reserve and if medically necessary*
- The coinsurance for durable medical equipment up to the Medicare-approved amount.

**Must call Medi-Call or APS for approval.*

Additional Days in a Hospital

If you are enrolled in Medicare, Medicare is the primary payer, and you may go to any hospital you choose. However, Medicare pays nothing for hospital stays beyond 150 days.

If You Exceed the Number of Inpatient Hospital Days Allowed Under Medicare
If you are enrolled in the Medicare Supplemental Plan and you exhaust all Medicare-allowed inpatient hospital days, you must call Medi-Call for approval of any additional inpatient hospital days. If your extended stay is approved, the Medicare Supplemental Plan will pay for the Medicare-approved expenses. So, if you are enrolled in the Medicare Supplemental Plan and you expect your hospital stay may exceed the number of days allowed under Medicare, you should choose a hospital within the SHP network or BlueCard Program so that any additional days beyond what Medicare allows will be covered by the Medicare Supplemental Plan.

You must also call Medi-Call for services related to home healthcare, hospice, durable medical equipment and Veterans Administration hospital services.

Skilled Nursing Facilities

The Medicare Supplemental Plan will pay these benefits after Medicare has paid benefits during a benefit period:

- The coinsurance, after Medicare pays, up to the Medicare-approved amount for days 21-100 (Medicare pays 100 percent for the first 20 days)
- 100 percent of the Medicare-approved rates beyond 100 days in a skilled nursing facility if medically necessary. (Medicare does not pay beyond 100 days.)* The maximum benefit per year for covered services beyond 100 days is $6,000.

**Must call Medi-Call for approval.*

Physician Charges

The Medicare Supplemental Plan will pay these benefits related to physician services approved by Medicare:

- The Medicare Part B deductible
- The coinsurance for the Medicare-approved amount for physician's services for surgery, necessary home and office visits, hospital visits and other covered physician's services

- The coinsurance for the Medicare-approved amount for physician's services rendered in the outpatient department of a hospital for treatment of accidental injury, medical emergencies, minor surgery and diagnostic services.

Home Healthcare

The Medicare Supplemental Plan will pay these benefits for medically necessary home healthcare services:

- The Medicare Part B deductible
- The coinsurance for any covered services or costs Medicare does not cover (Medicare pays 100 percent of Medicare-approved amount), up to 100 visits or $5,000 per benefit year, whichever occurs first. The plan does not cover services provided by a person who ordinarily resides in the home, is a member of the family or a member of the family of the spouse of the covered person
- 20 percent of Medicare-approved amount for durable medical equipment.

Private Duty Nursing Services

Private duty nursing services are services that are provided by a registered nurse (RN) or a licensed practical nurse (LPN) and that have been certified in writing by a physician as medically necessary. There is a $200 annual deductible that applies, regardless of the time of year you enroll in the plan. Medicare does NOT cover this service. Once the deductible is met, the Medicare Supplemental Plan will pay 80 percent of covered charges for private duty nursing in a hospital or in the home. Coverage is limited to no more than three nurses per day, and the maximum annual benefit per year is $5,000. The lifetime maximum benefit under the Medicare Supplemental Plan is $25,000.

Prescription Drugs

The Medicare Supplemental Plan covers prescription drugs when purchased from a participating pharmacy under the State Health Plan's Prescription Drug Program, managed by Medco. For more information, refer to pages 54-57.

When Traveling Outside the U.S.

Medicare does not cover services outside the United States and its territories. Because the Medicare Supplemental Plan does not allow benefits for services not covered by Medicare (other than private duty nursing), out-of-country services are not covered for Medicare Supplemental Plan subscribers.

Mental Health and Substance Abuse Services

If your claims are processed under the Medicare Supplemental Plan, you are encouraged, but not required, to call APS, the SHP's behavioral health manager, because Medicare guidelines will apply. However, if you exhaust Medicare's allowed inpatient hospital days, you must call APS for approval of any additional inpatient hospital days, including those in Veterans Administration hospitals. However, you are not required to use an APS network provider.

Note: *Any covered family members who are not eligible for Medicare and have their claims processed under the Standard Plan must call to register with APS and must use an APS network provider.*

Pap Test Benefit

If you are enrolled in Medicare, Medicare covers a Pap test, pelvic exam and clinical breast exam every other year. (These tests are covered yearly if you are at high risk. Check with Medicare for more information.) Medicare pays 100 percent for the Pap lab test and 80 percent of the Medicare-approved amount for the Pap test collection and the pelvic and breast exam. The Medicare Supplemental Plan pays the 20 percent coinsurance.

Please note that the Medicare Supplemental Plan will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women, ages 18-65. You may take advantage of this benefit in the years that Medicare does *not* pay. The deductible and coinsurance do not apply to this benefit. This benefit does not include the doctor's office visit or other lab tests.

Medicare Assignment: How Medicare Pays Its Share of the Cost of Your Care

If the provider accepts Medicare assignment, the provider accepts Medicare's payment plus the Medicare Supplemental Plan's payment as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and the Medicare Supplemental Plan pay combined. You pay the difference.

Example:
Medicare is primary. The hospital bill for a January admission is submitted to Medicare. If you are enrolled in Medicare and the Medicare Supplemental Plan, your Medicare claim will be processed like this:

$7,500	Medicare-approved amount
-1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

Next, the Medicare Supplemental Plan benefits are applied:

$1,024	Balance of the bill
-$1,024	Medicare Supplemental Plan pays Medicare Part A deductible
$ 0	You pay nothing.

Filing Medicare Claims as a Retiree

If you are retired and enrolled in Medicare, Medicare is your primary carrier. In most cases, your provider will file your Medicare claims for you.

Claims Filed in South Carolina

The Medicare claim should be filed first. Claims for Medicare-approved charges incurred in South Carolina should be transferred automatically from Medicare to the State Health Plan for you. Your mental health and substance abuse provider should file claims to APS with Medicare payment information. If you or your doctor have not received payment or notification from the plan within 30 days after the Medicare payment is received, one of you must send BlueCross BlueShield of South Carolina, claims administrator for the SHP, a claim form and a copy of your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," with your Benefits ID Number or Social Security Number written on it.

Claims Filed Outside South Carolina

If you receive services outside South Carolina, your provider will file its claim to the Medicare carrier in that state. When you receive your Medicare Summary Notice, formerly called the "Explanation of Medicare Benefits," you must send it to BlueCross BlueShield of South Carolina for medical or surgical services or to APS for mental health and substance abuse services. You also must include a claim form and an itemized bill.

Medical Care Outside the United States and Its Territories

Remember that the Medicare Supplemental Plan follows Medicare rules. Because Medicare does not provide coverage outside the U.S. and its territories, BlueCard Worldwide® coverage **is not** available to Medicare Supplemental Plan subscribers.

Railroad Retirement Claims

If you receive benefits from the Railroad Retirement Board (RRB), you must first file claims with the RRB. When you get an explanation of benefits from the RRB, mail it, along with an itemized bill and claim form, to BlueCross BlueShield of South Carolina for processing.

Filing Claims for Covered Family Members not Eligible for Medicare

Claims for covered family members who are not eligible for Medicare, but who are insured through the Medicare Supplemental Plan, are paid according to the Standard Plan provisions. Remember that some services require preauthorization by Medi-Call (see page 39) or APS Healthcare (see page 58).

HMO PLANS

This section explains some key distinctions of the health maintenance organizations (HMOs) and how they work together with Medicare. For a more complete overview of the plans, refer to the HMO section of the Health Insurance chapter of this guide or contact the HMO.

An HMO typically does not cover care outside its network, except in an emergency. If it is important to you to use particular providers, including physicians and hospitals, it is best to check to see if those providers participate in the HMO you wish to join.

Remember, you must live in an HMO's service area to enroll. Not all HMOs are available in all South Carolina counties. A list of counties where each HMO is offered is on page 62.

IF YOU ARE ELIGIBLE FOR MEDICARE

BlueChoice HealthPlan and CIGNA HMO and MUSC Options are available if you live in a county where they are offered. This section will focus on these plans.

Provider Networks

A traditional HMO provides a list of participating network doctors from which you choose a primary care physician. This doctor coordinates your care, which means you must contact him to be referred to specialists who also participate in the HMO's network. Network providers file the claims for you. If you belong to an HMO, the plan covers only medical services received from network providers. If you receive care outside the network, benefits are not paid. Typically, the only services from out-of-network providers that most HMOs cover are those for medical emergencies.

When Traveling Outside the Network or the U.S.

When traveling outside the CIGNA, MUSC Options or BlueChoice HealthPlan networks, you will be covered for emergency medical care. If your insurance identification cards are not recognized by the hospital, you may be required to pay for the services and then later file a claim for reimbursement.

Prescription Drug Programs

Each HMO offered for 2008 includes a prescription drug program with participating pharmacies.

HOW BLUECHOICE HEALTHPLAN AND MEDICARE WORK TOGETHER

BlueChoice HealthPlan pays only charges approved by Medicare. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance left after Medicare pays 80 percent for approved Part B services.

When you become eligible for Medicare, it is important to be enrolled in Part B if you are covered as a retiree or as a dependent of a retiree. Medicare becomes your primary insurance, and your health plan offered through EIP becomes the secondary payer. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

This plan pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) BlueChoice HealthPlan also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment, the provider will consider Medicare's payment plus BlueChoice HealthPlan's as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and BlueChoice HealthPlan pay combined. You pay the difference.

Example:
Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
-1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

BlueChoice HealthPlan pays all Medicare deductibles and coinsurance:

$1,024	BlueChoice HealthPlan pays Medicare Part A deductible
+6,476	Amount paid by Medicare
$7,500	Bill paid in full

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

Additional information about BlueChoice HealthPlan is in the HMO section of the Health Insurance chapter of this guide.

HOW CIGNA HMO AND MEDICARE WORK TOGETHER

CIGNA HMO pays the lesser of the subscriber's unreimbursed allowable charge under Medicare or CIGNA's normal liability. If the balance due on the claim is less than the normal liability, then CIGNA will pay the balance due.

CIGNA's benefit credit saving provisions apply. A *benefit credit* is the portion of the claim that CIGNA does not have to pay as a result of a coordination of benefits with Medicare. It may be applied to future claims during the calendar year. *Benefit credit saving* is the difference between what CIGNA would normally be responsible for paying and CIGNA's actual payment. It applies only to the family member who incurs the charge, and it expires at the end of the calendar year in which it is gained. Contact CIGNA for additional information.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

If you are enrolled in CIGNA's HMO plan your claim will be paid like this:

$7,500	Hospital bill
- 500	CIGNA's inpatient per occurrence copayment
$7,000	
x 80%	CIGNA's coinsurance
$5,600	CIGNA's liability in absence of Medicare
- 1,024	Amount paid by CIGNA in coordination with Medicare
$4,576	Benefit credit savings with CIGNA

Filing Claims as a Retiree

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

For more information, contact CIGNA.

HOW MUSC OPTIONS AND MEDICARE WORK TOGETHER

MUSC Options is available to Medicare recipients living in Berkeley, Charleston, Colleton and Dorchester counties. The health maintenance organization with a point of service option pays only charges approved by Medicare. It supplements Medicare by paying the Medicare Part A (hospital) and Part B (medical) deductibles in full. The plan also pays the 20 percent coinsurance left after Medicare pays 80 percent for Part B-approved services.

MUSC Options pays the coinsurance for hospitalization after the first 60 days in a general hospital or after the first 20 days in a skilled nursing facility. (Medicare pays 100 percent of the Medicare-approved amount for the first 60 days in a general hospital and for the first 20 days of skilled nursing care.) It also pays the Medicare coinsurance for days 21-100 for skilled nursing care.

If the provider accepts Medicare assignment, the provider will consider Medicare's payment plus MUSC Options' as payment in full. If the provider does not accept Medicare assignment, the provider may charge more than what Medicare and MUSC Options pay combined. The subscriber would pay the difference.

Example:

Medicare is primary. The bill is submitted to Medicare for a January hospital admission:

$7,500	Hospital bill
- 1,024	Medicare Part A deductible for 2008
$6,476	Medicare payment
$1,024	Balance of the bill

MUSC Options pays all Medicare deductibles and coinsurance:

$1,024	MUSC Options pays Medicare Part A deductible
+6,476	Amount paid by Medicare
$7,500	Bill paid in full

If you are retired and enrolled in Medicare, Medicare is your primary coverage. In most cases, your provider will file your Medicare claims for you. The Medicare claim should be filed first.

Additional information about MUSC Options is in the HMO section of the Health Plan chapter of this guide.

DENTAL BENEFITS

If you retire from a participating employer, you can continue your State Dental Plan and Dental Plus coverage if you meet the eligibility requirements (see page 171). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election with EIP and Employment Verification Record within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment period, which will be in October 2009, or until you become eligible to change your coverage due to a special eligibility situation.

If you are not eligible for retiree insurance, you may request COBRA continuation coverage within 60 days of loss of coverage or notification of the right to continue coverage, whichever is later.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period (October 2009). Coverage will be effective the following January 1. You also may enroll within 31 days of a special eligibility situation. For information on the State Dental Plan and Dental Plus, see pages 95-101.

MONEYPLU$

MoneyPlu$ is not available in retirement. However, when you retire, you may be able to continue your **Medical Spending Account** (MSA) through the end of the plan year, including the grace period. If you know your retirement date during the October enrollment period, you can divide your MSA contributions by the number of paychecks you will receive before retirement. For example, if you are retiring in June, you could have your contributions divided among half the number of paychecks you receive annually. Another option is to have the amount remaining in your yearly contribution deducted from your last few paychecks. You may also be able to continue your account on an after-tax basis through COBRA. See page 161 for more information. If you wish to continue your account, contact your benefits administrator within 31 days of your last day at work and fill out the appropriate forms.

If you do not wish to continue your MSA, you have 90 days from your last day at work to submit claims for eligible expense incurred before you left employment.

You cannot continue contributing to your **Dependent Care Spending Account** after you retire. However, you can request reimbursement for eligible expenses incurred while you were employed until you exhaust your account or the plan year ends.

LONG TERM CARE

Long Term Care (LTC) refers to a wide range of personal healthcare services for people of all ages who suffer from chronic conditions. These individuals need assistance with day-to-day activities, such as bathing, eating, continence, toileting, transferring and/or dressing or supervision due to cognitive impairment, such as Alzheimer's disease. Care can be provided in a nursing home, in an assisted living facility, at home or in the community, such as in an adult day-care center.

Long Term Care Services Already Covered

Medicare covers some home healthcare and skilled nursing facility services. However, there are limits on the dollar amounts paid and the number of visits allowed. Neither the State Health Plan nor Medicare covers custodial care services. To qualify for Medicaid, you must exhaust most of your assets and income.

Continuing Coverage Into Retirement

If you are enrolled in LTC when you retire, your coverage will be continued. Coverage will also continue for any family member covered when you retire. You will receive a letter regarding continuation of your LTC insurance, which you will need to sign and return to EIP.

Enrolling in Coverage at Retirement

You and/or your spouse/surviving spouse may apply to enroll in Long Term Care at any time or increase your daily benefit amount by providing medical evidence of good health. Ask Aetna or EIP for information and an application. If you are approved for coverage, Aetna will send confirmation to you and to EIP.

Premiums

You pay the entire cost of LTC coverage for yourself and your spouse, if he or she is enrolled. Premiums will be based on your age at the time of your application. (Some exceptions may apply.) Premiums are on pages 214-216. If you are retired from a state agency, a college, a university or a school district, the premiums will be deducted from your monthly S.C. Retirement Systems check. If the amount is not enough to cover your health, dental and LTC premiums, EIP will bill you directly for LTC premiums. You may also request in writing to have your premiums drafted from your bank account. Local subdivision retirees will be billed by the local subdivision.

LIFE INSURANCE

You may want to think about your life insurance needs in retirement. If you continue or convert your policy, your premiums may increase.

$3,000 Basic Life Insurance

This benefit is given to you as an active employee and *ends* with retirement or when you leave your job for another reason. You may convert the $3,000 Basic Life to an individual policy within 31 days of the date coverage ends. Contact your benefits office or EIP for additional information.

OPTIONAL LIFE INSURANCE

This is how you can carry your Optional Life Insurance into retirement through The Hartford:

- If you retired on or after January 1, 2001, you may continue your coverage in $10,000 increments up to the final face value of coverage until age 75. At age 70, coverage is reduced for active employees and retirees.
- You may convert your Optional Life coverage to an individual policy.
- You may split your coverage between individual life insurance and term life insurance.

To continue your coverage, you must complete the required enrollment forms within 31 days of your date of retirement. **If you are leaving employment due to a disability and are continuing Optional Life coverage under the 12-month waiver provision, you must file for continuation within 31 days of the end of the 12-month waiver.** If you have questions about continuing your coverage as a retiree, contact your benefits office or EIP.

If you participate in the Teacher and Employee Retention Incentive (TERI) program, you can continue your benefits as an active employee, provided you are eligible. When the TERI period ends you must file for retiree benefits within 31 days as indicated above.

If you return to work as a full-time, active employee with a participating employer, you must choose whether to enroll in Optional Life insurance coverage as an active employee or to continue your retiree coverage. If you refuse to enroll as an active employee, you also refuse the $3,000 Basic Life benefit, and Optional and/or Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

Retiree life insurance coverage does not include the Living Benefit Option, the Accidental Death and Dismemberment Option, the Travel Assistance Program or the EstateGuidance℠ Program.

Premiums are on pages 217-220.

Optional Life Insurance if You Become Disabled

If you become totally disabled while covered as an active employee, your life insurance will be continued for up to 12 months from the last day you are physically at work, provided:

- Your total disability began while you were covered by this Optional Life Insurance plan
- Your total disability began before you reached age 69 and
- The group Optional Life Insurance policy does not end.

Your premiums will be waived for up to 12 months from the last day you were physically at work as long as you are totally disabled. The 12-month waiver period begins the first of the month following your last day physically at work. For your premiums to be waived, you must provide proof of disability to your benefits administrator within one year after the last day you were physically at work. If you return to work during the 12-month waiver period and work one full week, the premium waiver period should end. If you must leave employment again due to total disability, the 12-month waiver will start over from the last day you were physically at work.

If you wish to continue coverage, you must file for continuation through The Hartford within 31 days of the date the waiver ends. Contact your benefits office for additional information.

DEPENDENT LIFE INSURANCE

Any Dependent Life Insurance coverage you have will end when you leave active employment. Your covered dependent may convert the insurance coverage to an individual policy. The dependent must apply to The Hartford, in writing, within 31 days of the date of coverage ends and pay the required premiums.

LONG TERM DISABILITY

Disability insurance protects an employee and his family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic and Supplemental Long Term Disability end.

Basic Long Term Disability

This benefit may not be continued or converted to an individual policy.

Supplemental Long Term Disability

Generally, you may not continue Supplemental Long Term Disability coverage in retirement. However, if you are retiring or leaving employment, but plan to be self employed or work for an employer that does not have a supplemental long term disability program, see page 136 for information about continuing coverage.

THE VISION CARE PROGRAM

This discount program is available to retirees, as well as to full-time and part-time employees, dependents, survivors and COBRA subscribers. Please refer to page 21 for more information.

Comparison of Health Plans for Retirees

	High Deductible Health Plan		Preferred Provider Organization	
Type	Once the deductible has been met, other benefits are paid at the same level as the SHP Standard Plan.		To receive the higher level of benefits, subscribers should choose a network provider.	
Plan	**SHP Savings Plan**		**SHP Standard Plan**	
Availability	Coverage worldwide		Coverage worldwide	
Annual Deductible *Single* *Family*	**$3,000** **$6,000**[1]		**$350** **$700**	
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient hospital: **$75** per-occurrence deductible Emergency care: **$125** per-occurrence deductible	
Coinsurance	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%	**In-network** Plan pays 80% You pay 20%	**Out-of-network** Plan pays 60% You pay 40%
Coinsurance Maximum *Single* *Family*	**$2,000** **$4,000** (excludes deductibles)	**$4,000** **$8,000** (excludes deductibles)	**$2,000** **$4,000** (excludes deductibles)	**$4,000** **$8,000** (excludes deductibles)
Physicians Office Visits	Chiropractic benefits limited to **$500** a year, per person, after deductible		**$10** per-occurrence deductible, then:	
	No per-occurrence deductibles		Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%		
Prescription Drugs	Participating pharmacies and mail order only: You pay 100% of the plan's allowable charge until the annual deductible is met. Afterward, the plan will reimburse 80% of the allowable charge. The remaining 20% will be credited to your coinsurance maximum.		Participating pharmacies only (up to 31-day supply): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**	
Mental Health/ Substance Abuse	Participating providers only. Call 800-221-8699. Subject to above deductibles and coinsurance.		Participating providers only. Call 800-221-8699. Subject to above deductibles and coinsurance.	
Lifetime Maximum	**$1,000,000**		**$1,000,000**	

[1] *If more than one family member is covered, no family members will receive benefits, other than preventive, until the $6,000*
[2] *There is no outpatient facility copay for services performed at a Medical University of South Carolina outpatient facility.*
Please Note: *This chart is just a summary of your benefits. Consult the Retirement/Disability Retirement and Health Insurance*

and Dependents NOT Eligible for Medicare

	Traditional HMO		HMO with a Point of Service Option (POS)	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.		Medically necessary benefits are available out-of-network at a lower benefit.	
	BlueChoice HealthPlan	**CIGNA HMO**	**MUSC Options**	
	Available in all counties in South Carolina	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*	Available in these S.C. counties: *Berkeley, Charleston, Colleton and Dorchester*	
	$250 **$500** (Does not apply to copays)	None	**In-network** None	**Out-of-network** **$500** **$1,500**
	Inpatient: **$200** copay Outpatient: **$100** copay/first 3 visits Emergency care: **$125** copay HMO pays 90% after copays and deductible. You pay 10% **$35** Urgent care copay, then HMO pays 100%	Inpatient: **$500** copay per admission. Then HMO pays 80% after copays. Outpatient facility: **$250** copay per admission. Then HMO pays 80% after copays Emergency care: **$100** copay. Then HMO pays 100%	Inpatient: **$300** copay Outpatient facility: **$100**[2] copay Emergency care: **$150** copay Urgent care: **$50** copay	HMO pays 60% after annual deductible You pay 40%
	HMO pays 90% after deductible and copays You pay 10%	HMO pays 80% after copays You pay 20%	HMO pays 100% after copays	HMO pays 60% after deductible You pay 40%
	$1,500 **$3,000** (excludes deductibles)	**$2,000** **$4,000** (includes inpatient, outpatient, copays and coinsurance)	N/A	**$3,000** **$9,000** (excludes deductibles)
	$15 PCP copay **$15** OB/GYN well woman exam **$30** specialist copay	**$15** PCP copay **$15** OB/GYN exam **$30** specialist copay	**$25** PCP copay **$25** OB/GYN well woman exam - 2 per benefit period **$50** specialist copay with or without referral	HMO pays 60% of allowable charge after annual deductible You pay 40% No preventive care benefits out-of-network
	Participating pharmacies only (up to 31-day supply): **$7** generic, **$35** preferred brand, **$55** non-preferred brand, **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$14** generic, **$70** preferred brand, **$110** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic, **$25** preferred brand, **$50** non-preferred brand Mail order (up to 90-day supply): **$14** generic, **$50** preferred brand, **$100** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$100** deductible, then: **$10** tier 1 (generic—lowest cost), **$30** tier 2 (brand—higher cost), **$50** tier 3 (brand—highest cost), **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$25** tier 1, **$75** tier 2, **$125** tier 3	
	Participating providers only. Call 800-969-1032 Inpatient: **$200** copay, then HMO pays 90% Outpatient: **$30** specialist copay	Participating providers only. Inpatient: **$500** copay, then 80% covered Outpatient: **$30** specialist copay	CBA must preauthorize inpatient and outpatient **$50** outpatient copay	HMO pays 60% of allowable charge after annual deductible is paid
	$1,000,000	**$1,000,000**	**$1,000,000**	

annual family deductible is met.

chapters for details.

Comparison of Health Plans for Retirees

Plan	SHP Savings Plan	SHP Standard Plan	
Inpatient Hospital Days[1]	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Skilled Nursing Care	Plan pays 80% You pay 20% up to **$6,000** or 60 days, whichever is less (Medi-Call required)	Plan pays 80% You pay 20% up to **$6,000** or 60 days, whichever is less (Medi-Call required)	
Private Duty Nursing	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Home Healthcare	**$5,000** or 100 visits, whichever is less, if Medi-Call approved	**$5,000** or 100 visits, whichever is less, if Medi-Call approved	
Hospice Care	**$6,000** lifetime maximum, including **$200** bereavement counseling	**$6,000** lifetime maximum, including **$200** bereavement counseling	
Durable Medical Equipment	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Routine Mammography Screening	Ages 35-74 in participating facilities only; guidelines apply	Ages 35-74 in participating facilities only; guidelines apply	
Pap Test	Ages 18-65 Routine or diagnostic	Ages 18-65 Routine or diagnostic	
Ambulance	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	
Eyeglasses/Hearing Aid	None, except for prosthetic lenses from cataract surgery Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery Discount under the Vision Care Program	

[1]*Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room general nursing and*

and Dependents NOT Eligible for Medicare

	BlueChoice HealthPlan	CIGNA HMO	MUSC Options	
	Plan pays 90% You pay 10% with a **$200** copay and coinsurance	Plan pays 80% You pay 20% with **$500** copay and coinsurance maximum	**In-network** Plan pays 100% You pay **$300** copay	**Out-of-network** Plan pays 60% You pay 40% Subject to deductible
	Plan pays 90% You pay 10% up to 120 days	Plan pays 80% You pay 20% up to 180 days	Plan pays 100% up to **$6,000** or 60 days, whichever is less, per benefit period	Plan pays 60% You pay 40% Subject to deductible
	Plan pays 90% You pay 10% up to 60 days	Plan pays 100%	Plan pays 100%	Covered in-network only
	Plan pays 90% You pay 10%	Plan pays 100% up to 60 visits	Plan pays 100% up to **$5,000** or 100 visits, whichever is less, per benefit period	Plan pays 60% You pay 40% Subject to deductible
	Plan pays 90% You pay 10%	Not included	Plan pays 100% **$6,000** lifetime maximum	Plan pays 60% You pay 40% Subject to deductible
	$5,000 maximum Plan pays 90% You pay 10%	**$3,500** maximum Plan pays 100%	Plan pays 100%	Covered in-network only
	Plan pays 100%; guidelines apply	Plan pays 100%	Plan pays 100%	Covered in-network only
	Routine: any age; 2 per year; **$15** copay Diagnostic: copay/coinsurance	Plan pays 100% You pay **$15** copay	Routine: **$25** copay Diagnostic: **$50** copay	Covered in-network only
	Plan pays 90% You pay 10%	Plan pays 80% You pay 20%	Plan pays 100%	Plan pays 60% You pay 40% Subject to deductible
	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider	Plan pays up to **$75** for routine eye exam once per benefit period Plan pays up to **$75** for eyewear once every other benefit period	

miscellaneous hospital services and supplies.

Comparison of Health Plans for Retirees

Type			PPO	
			To receive a higher level of benefits, subscribers should choose an in-network provider.	
Plan	**Medicare**	**Medicare Supplemental**	**SHP Standard Plan**	
Availability	United States (Contact Medicare for information about any services outside of the United States)	Same as Medicare	Coverage worldwide	
Cancellation Policy	None	Canceled upon request or for non-payment of premiums	Canceled upon request or for non-payment of premiums	
Annual Deductible	Part A: **$1,024** (per benefit period) Part B: **$135**	Pays Medicare Part A and Part B deductibles	**$350** (single) **$700** (family) Carve-out method applies	
Per-occurrence Deductible	Inpatient hospital: Part A deductible (**$1,024** per benefit period)	Pays Medicare Part A deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)	Outpatient hospital: **$75** deductible Emergency care: **$125** deductible (Call Medi-Call for hospital stays over 150 days, skilled nursing, private duty nursing, home healthcare, durable medical equipment and VA hospital services)	
Coinsurance	Part A: 100% Part B: 80% (You pay 20%)	Pays Part B coinsurance of 20%	Carve-out method applies Plan allows 80%	
Coinsurance Maximum	None	None	**In-network** **$2,000** (single) **$4,000** (family) Excludes deductible	**Out-of-network** **$4,000** (single) **$8,000** (family)
Physician Visits	Plan pays 80% You pay 20% Routine annual physicals and OB/GYN exams not covered	Plan pays Part B coinsurance of 20%	Carve-out method applies; **$10** per-occurrence deductible; Plan allows 80% in-network, 60% out-of-network Well Child Care visits and immunizations paid at 100% in-network up to age 18.	
Prescription Drugs	Covered under Medicare Part D. However, subscribers to health plans offered through the Employee Insurance Program have creditable coverage and therefore do not need to sign up for Part D.	Participating pharmacies only (up to 31-day supply): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail-order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**	Participating pharmacies only (up to 31-day supply): **$10** tier 1 (generic—lowest cost), **$25** tier 2 (brand—higher cost), **$40** tier 3 (brand—highest cost) Mail order (up to 90-day supply): **$25** tier 1, **$62** tier 2, **$100** tier 3 Copay max: **$2,500**	
Mental Health/ Substance Abuse	Inpatient: Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$256**/day for days 61-90; You pay **$512**/day for days 91-150 (subject to 60 lifetime reserve days); You pay all costs after 150 days. Outpatient: Plan pays 50% (Part B deductible applies)	Inpatient: Plan pays Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% after 150 days (APS approval required). Outpatient: Plan pays Medicare deductible, 50% coinsurance	Carve-out method applies Plan allows 80% in-network (APS participating providers only if hospital stay exceeds 150 days)	
Lifetime Maximum	**None**	**$1,000,000**	**$1,000,000**	

and Dependents Eligible for Medicare

	Traditional HMO		HMO with a Point of Service Option (POS)	
	All care must be directed by a primary care physician (PCP) and approved by the HMO.		Medically necessary benefits are available out-of-network at a lower benefit.	
	BlueChoice HealthPlan	**CIGNA HMO**	**MUSC Options**	
	Available in all South Carolina counties	Available in all S.C. counties, **except**: *Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda*	Available in the following S.C. counties: *Berkeley, Charleston, Colleton and Dorchester*	
	Canceled upon request or for non-payment of premiums	Canceled upon request or for non-payment of premiums	Canceled upon request or for non-payment of premiums	
	Pays Medicare Part A and Part B deductibles	No deductible; Pays lesser of unreimbursed Medicare-allowed expenses or plan's normal allowable charge	Pays Medicare Part A and Part B deductibles	
	Pays Medicare Part A deductible	Inpatient: **$500** copay Outpatient facility: **$250** copay Emergency care: **$100** copay	Pays Medicare Part A deductible	
	Pays Part B coinsurance of 20%	Plan pays 80% of unreimbursed Medicare-allowed expenses.	Pays Part B coinsurance of 20%	
	None	**$2,000** (single) **$4,000** (family) (excludes certain copays)	**In-network** None	**Out-of-network** **$3,000** (single) **$9,000** (family) (excludes deductibles)
	Plan pays Part B coinsurance of 20%	**$15** PCP copay **$15** OB/GYN exam **$30** specialist copay Plan pays 80% of unreimbursed Medicare-allowed charges	Plan pays Part B coinsurance of 20%	HMO pays 60% of allowance after annual deductible You pay 40% No preventive care benefits out-of-network
	Participating pharmacies only (up to 30-day supply): **$7** generic **$35** preferred brand **$55** non-preferred brand **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$14** generic **$70** preferred brand **$110** non-preferred brand	Participating pharmacies only (up to 30-day supply): **$7** generic **$25** preferred brand **$50** non-preferred brand Mail-order (up to 90-day supply): **$14** generic **$50** preferred brand **$100** non-preferred brand No copay max	Participating pharmacies only (up to 30-day supply): **$100** deductible, then: **$10** tier 1 (generic—lowest cost), **$30** tier 2 (brand—higher cost), **$50** tier 3 (brand—highest cost), **$100** specialty pharmaceuticals Mail order (up to 90-day supply): **$25** tier 1, **$75** tier 2, **$125** tier 3	
	Inpatient: Plan pays Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	Participating providers only: **$40** copay per office visit Inpatient: **$500** copay per admission Plan pays 80% of unreimbursed Medicare-allowed expenses	Inpatient: Plan pays Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days Outpatient: Plan pays Medicare deductible, 50% coinsurance	
	$1,000,000	**$1,000,000**	**$1,000,000**	

Comparison of Health Plans for Retirees

Plan	Medicare	Medicare Supplemental	SHP Standard Plan	
Inpatient Hospital Days	Plan pays 100% for days 1-60 (Part A deductible applies); You pay **$256**/day for days 61-90; You pay **$512** for days 91-150 (subject to 60 lifetime reserve days); You pay all costs beyond 150 days	Plan pays: Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days (Medi-Call approval required)	Carve-out method applies Plan allows 80% (Call Medi-Call if hospital stay exceeds 150 days)	
Skilled Nursing Care	Plan pays 100% for days 1-20; You pay **$128** for days 21-100	Plan pays **$128** for days 21-100; Plan pays 100% beyond 100 days (Medi-Call approval required) up to **$6,000** or 60 days, whichever is less	Carve-out method applies Plan allows 80%, up to **$6,000** or 60 days, whichever is less. (Call Medi-Call if hospital stay exceeds 100 days)	
Private Duty Nursing	Not covered	**$200** annual deductible Plan pays 80% if Medi-Call approved You pay 20% **$5,000** annual maximum **$25,000** lifetime maximum	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call approval required)	
Home Healthcare	Plan pays 100%	Medi-Call available to assist with referrals Up to **$5,000** or 100 visits, whichever is less	Carve-out method applies Plan allows 80% You pay 20% up to **$5,000** or 100 visits, whichever is less	
Hospice Care	Plan pays 100%	Medi-Call available to assist with referrals	Medi-Call available to assist with referrals	
Durable Medical Equipment	Plan pays 80% (Medicare approval required) You pay 20%	Plan pays 20% coinsurance (Medi-Call required)	Carve-out method applies Plan allows 80% (Medi-Call approval required)	
Routine Mammography Screening	Age 40 and older, one every year Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Ages 35-74 in participating facilities only; guidelines apply	
Pap Test	Routine every two years (yearly if high risk) Plan pays 100% for Pap test Plan pays 80% for exam	Plan pays 20% coinsurance. Otherwise, plan pays yearly for one routine Pap test for covered women ages 18-65. Diagnostic only age 66 and older.	Routine yearly ages 18-65; Diagnostic only age 66 and older; Plan allows 100% for Pap test (Carve-out method applies when Medicare pays)	
Ambulance	Plan pays 80% You pay 20%	Plan pays 20% coinsurance	Carve-out method applies Plan allows 80%	
Eyeglasses/ Hearing Aid	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	None, except for prosthetic lenses from cataract surgery. Discount under the Vision Care Program	

and Dependents Eligible for Medicare

	BlueChoice HealthPlan	CIGNA HMO	MUSC Options
	Plan pays: Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days	Plan pays 80% or unreimbursed Medicare-allowed expenses after **$500** copay	Plan pays: Medicare deductible; **$256** coinsurance for days 61-90; **$512** coinsurance for days 91-150; 100% beyond 150 days
	Plan pays **$128** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)	Plan pays 80% or unreimbursed Medicare-allowed expenses, up to 180 days	Plan pays **$128** for days 21-100; Plan pays 100% beyond 100 days (limited to 120 days)
	Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)	Plan pays 100%	Plan pays 80%; You pay 20% and **$200** annual deductible **$5,000** annual maximum **$25,000** lifetime maximum (limited to 120 days)
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses, up to 60 visits	(Medicare pays 100% of covered charges)
	(Medicare pays 100% of covered charges)	Plan pays 100% or unreimbursed Medicare-allowed expenses	(Medicare pays 100% of covered charges)
	Plan pays 20% coinsurance	**$3,500** maximum Plan pays 100% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
	Plan pays 20% coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
	Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam two times per year after **$15** copay. Diagnostic: copay/coinsurance	Plan pays 100% or unreimbursed Medicare-allowed expenses after **$15** copay	Plan pays 20% coinsurance. Otherwise, pays routine OB/GYN exam after **$25** copay. Diagnostic: **$50** copay
	Plan pays 20% coinsurance	Plan pays 90% or unreimbursed Medicare-allowed expenses	Plan pays 20% coinsurance
	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)	One exam every two years (**$10** copay) Must use a participating provider	One exam for glasses or contacts per year (**$45** copay for contacts exam). One pair of glasses every other year (from designated selection)

Please note: *This chart is just a summary of your benefits. Please consult the retirement and health insurance chapters for details.*